CHAPTER 13
SECTION 3.5

AMBULANCE SERVICES

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I. ISSUE

How are ambulance services to be reimbursed?

II. POLICY

A. General.

1. Allowable charge/cost methodology will be used to adjudicate ambulance claims. Information from ambulance companies in each service area is to be used in the development of prevailing base rate screens.

2. In contractor service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an additional payment based on prevailing mileage charges may be allowed. Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes its basic charge for ambulance services and its rate for loaded mileage.

3. When there are both basic and advanced life support (ALS) ambulances furnishing services in a state, separate prevailing profiles are to be developed for each type. The ALS prevailing charge may be used as a basis for payment when an ALS ambulance is used, but only if use of the ALS ambulance is specifically justified on the claim (i.e., the required capabilities of the ALS which were not available in a basic ambulance and why they were required). If justification is not submitted, development is not required and payment will be based on the profile for basic ambulance service.

B. Charges made in addition to base rates and mileage charges. The following guidelines shall be used when an ambulance supplier bills for other than the base rate and a mileage charge.

1. Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the general ambulance services and shall be included in the cost of, or charge for, the trip. Any additional charge for such items is to be denied.

2. A separate reasonable charge based on actual quantities used may be recognized for non-reusable items and disposable supplies such as oxygen, gauze, dressings and disposable linens required in the care of the patient during his trip.

3. When separate charges are billed for specific covered ALS services, allowable charge profiles for each such service should be developed. When a claim is filed for any one or a combination of such covered services, the maximum allowable charge for the total ambulance service will be the sum of the allowable amounts for the supplier's base rate, any mileage charges, and the specific specialized service(s). When the contractor does not have a profile for the specialized service, it may use the profile for an equivalent service as a guideline for determining an appropriate allowance. For example, if an ambulance supplier submits a separate additional charge for covered EKG monitoring and the contractor does not have a prevailing profile for such charges submitted by an ambulance supplier, the contractor may use the profiles for procedures 93012 and 93270 as guidelines for determining the allowable amount.

4. Although separate charges may be allowed for specific ALS services, no separate charge can be allowed for the personnel manning the ALS, even though they are obviously more highly qualified than the personnel in a basic ambulance. Their costs are to be included in the base and mileage charges.

C. The cost-sharing of ambulance services and supplies will be in accordance with the status of the patient at the time the covered services and supplies are rendered (32 CFR 199.4(a)(4)).

1. Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, MTF, or VA hospital will always be cost-shared on an outpatient basis. Transfers from a hospital to a patient's residence will also be considered an outpatient service for reimbursement under the program. Refer to Chapter 13, Section 11.1, paragraph II.A. and paragraph II.C. for application of deductible and cost-share amounts for outpatient care.

2. Ambulance transfers between hospitals (acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals) will be cost-shared on an inpatient basis. The following guidelines are consistent with the inpatient deductible and cost-sharing provisions provided in Chapter 13, Section 11.1, paragraph II.B. and paragraph II.D.:

a. Deductible Amount Inpatient: None.

b. Cost-Share Amount Inpatient.

(1) Active Duty Dependent: No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

(2) Other Beneficiary: The cost-share applicable to inpatient care for other than active duty dependent beneficiaries is twenty-five percent (25%) of the TRICARE/CHAMPUS-determined allowable amount.

3. Under the above provisions, active duty dependents would only be liable for the difference between the billed charges and the TRICARE/CHAMPUS-determined allowable charge if the provider did not accept assignment for ambulance transfers between hospitals.

4. Transfers to a MTF or VA hospital after treatment at, or admission to, an emergency room or civilian hospital will be cost-shared on an inpatient basis if ordered by other than a representative of the MTF.

5. Medically necessary ambulance transfers from an emergency room (ER) to a hospital more capable of providing the required level of care will also be cost-shared on an inpatient basis.

NOTE: This is consistent with current policy of cost-sharing ER services as inpatient when an immediate inpatient admission for acute care follows the outpatient ER treatment.

III. POLICY CONSIDERATIONS

A. Ambulance Membership Programs.

1. Ambulance membership programs typically charge an annual fee for a subscription to an ambulance service. The ambulance provider agrees to accept assignment on all benefits from third party payers for medically necessary services. By paying the annual fee, the covered family members pay no additional fees (including third party cost-shares and deductibles) to the ambulance service.

2. When a beneficiary pays premiums to a pre-paid ambulance plan, the premiums are considered to fulfill the beneficiary's cost-share and deductible requirements. Under this arrangement, the ambulance membership program becomes analogous to a limited supplemental plan.

B. When an ambulance company bills a flat fee for ambulance transport within its service area, reimbursement will be at the lesser of the billed amount (flat fee) or the statewide prevailing for HCPCS 0300 through 0310 subject to applicable beneficiary cost-sharing.

C. See Chapter 7, Section 2.1 for additional specific information on the coverage of ambulance services.

D. The TRICARE/CHAMPUS national allowable charge system used to reimburse professional services discussed in Chapter 13, Section 1.1, Section 1.2, Section 1.3, and Section 1.5 does not apply to ambulance claims. The above reimbursement guidelines are to be used by the contractors.

E. See Chapter 11, Section 7.1 and OPM Part Two, Chapter 22 for information/payment of ambulance services in foreign countries.

F. Itemization requirements are dictated by the particular HCPC codes used in filing an ambulance claim. For example, if HCPC code A0310 is filed no itemization is required since mileage and disposable supplies are included in the global charge. If however, HCPC code A0370 is filed itemization of base rate, mileage and disposable supply charges are required in

order to process and pay the claim. Since there is only one HCPC code for air ambulance transport, the ambulance company will either submit a global rate or itemize out the various charges which will have to be combined by the contractor to pay under the A0030 prevailing.

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